Person Centered Planning process 1915(c) - § 441.725 – Initial Assessment Review Tool

(a) Person-centered planning process. Based on the independent assessment required in §441.720, the State must develop (or approve, if the plan is developed by others) a written service plan jointly with the individual (including, for purposes f this paragraph, the individual and the individual's authorized representative if applicable). **The person-centered planning process is driven by the individual. The process:**	
(1) Includes people chosen by the individual	
(2) Provides necessary information and support to ensure that the individual directs the process to the maximum extent possible, and is enabled to make informed choices and decisions.	
(3) Is timely and occurs at times and locations of convenience to the individual	
(4) Reflects cultural considerations of the individual and is conducted by providing information in plain language and in a manner that is accessible to individuals with disabilities and persons who are limited English proficient, consistent with §435.905(b) of this chapter.	
(5) Includes strategies for solving conflict or disagreement within the process, including clear conflict of interest guidelines for all planning participants.	
(6) Offers choices to the individual regarding the services and supports the individual receives and from whom.	
(7) Includes a method for the individual to request updates to the plan, as needed.	
(8) Records the alternative home and community-based settings that were considered by the individual	
(b) The person-centered service plan. The person-centered service plan must reflect the services and supports that are important for the individual to meet the needs identified through an assessment of functional need, as well as what is important to the individual with regard to preferences for the delivery of such services and supports. **Commensurate with the level of need of the individual, and the scope of services and supports available under the State plan HCBS benefit, the written plan must:**	
(1) Reflect that the setting in which the individual resides is chosen by the individual. The State must ensure that the setting chosen by the individual is integrated in, and supports full access of individuals receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community to the same degree of access as individuals not receiving Medicaid HCBS.	
(2) Reflect the individual's strengths and preferences.	
(3) Reflect clinical and support needs as identified through an assessment of functional need.	
(4) Include individually identified goals and desired outcomes.	
(5) Reflect the services and supports (paid and unpaid) that will assist the individual to achieve identified goals, and the providers of those services and supports, including natural supports. Natural supports are unpaid supports that are provided voluntarily	

	to the individual in lieu of State plan HCBS.	
(6)	Reflect risk factors and measures in place to minimize them, including individualized backup plans and strategies when needed.	
(7)	Be understandable to the individual receiving services and supports, and the individuals important in supporting him or her. At a minimum, for the written plan to be understandable, it must be written in plain language and in a manner that is accessible to individuals with disabilities and persons who are limited English proficient, consistent with §435.905(b) of this chapter.	
(8)	Identify the individual and/or entity responsible for monitoring the plan.	
(9)	Be finalized and agreed to, with the informed consent of the individual in writing, and signed by all individuals and providers responsible for its implementation.	
(10)	Be distributed to the individual and other people involved in the plan.	
(11)	Include those services, the purchase or control of which the individual elects to self-direct, meeting the requirements of §441.740.	
(12)	Prevent the provisions of unnecessary or inappropriate services and supports.	
(13)	Document that any modification of the additional conditions, under §441.710(a)(1)(vi)(A) through (D) of this chapter, must be supported by a specific assessed need and justified in the person-centered service plan. **The following requirements must be documented in the person-centered service plan:**	
	(i) Identify a specific and individualized assessed need;	
	(ii) Document the positive interventions and supports used prior to any modifications of the person-centered service plan;	
	(iii) Document less intrusive methods of meeting the need that have been tried but did not work;	
	(iv) Include a clear description of the condition that is directly proportionate to the specific assessed need;	
	(v) Include a regular collection and review of data to measure the ongoing effectiveness of the modification;	
	(vi) Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated;	
	(vii) Include informed consent of the individual; and	
	(viii) Include an assurance that the interventions and supports will cause no harm to the individual.	
(c) **Reviewing the person-centered service plan.** The person-centered service plan must be reviewed and revised upon assessment of functional need as required in §441.720, at least every 12 months, when the individual's circumstances or needs change significantly, and at the request of the individual.		